Connecticut Community KidCare

STATUS REPORT

A
Quarterly Report Submitted to

THE CONNECTICUT GENERAL ASSEMBLY

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Purpose:

This document serves ans the ninth quarterly report issued by the Department of Children and Families and Social Services regarding the status of the children's behavioral health program, Connecticut Community KidCare. As required by PA01-2, this document serves to update the General Assembly on the progress of this system reform.

Programmatic Update:

Emergency Mobile Services:

The statewide network of children's mobile crisis teams continues to respond to urgent calls from a variety of sources seeking immediate assistance or consultation regarding a child's behavioral health concern. The sixteen emergency mobile crisis teams have answered almost 1, 100 calls since the program's inception in 2002.

During the first quarter on FY'05 (July 1, 2004 – September 30, 2004) there were **1128** calls made to the mobile crisis teams throughout the state. Services were provided to 542 boys and 586 girls. 774 children referred for service (2/3) had no DCF involvement, while 354 (1/3) were involved with the Department. Almost half of the calls (591) were made on behalf of children ages 11 –15. This age group has consistently been the focus of the majority of the calls coming into the units. However, during this quarter, all age groups were represented in the utilization of mobile crisis services. 93 calls came in regarding children under the age of five, 267 calls were received regarding children between the ages of 6-10, and 177 calls were regarding youth aged 16 and above.

Consistent with past trends, the majority of calls to Emergency Mobile crisis teams were made by parents or caregivers (405). Notably, calls from schools were low this quarter (200) due to the impact of summer vacation. DCF offices were the next highest referral source (124), with the remaining calls generated from a variety of sources including the DCF Hotline, the courts, foster families, other social service and clinical agencies, the police and shelters.

Of the 1128 calls received, 278 required phone consultation only. 284 calls resulted in an emergency visit to the child's home, 239 calls received follow-up in a clinic office and 119 callers were seen in one of the EMS offices. Visits to shelters, schools and hospital emergency rooms accounted for the remaining 208 calls.

Care Coordination:

Care Coordinators continue to provide assistance to families who need help to organize their child's treatment and identify/procure appropriate service. **Approximately 600** children received this service during this quarter (includes, discharges, admissions and carry forwards from previous quarter). 198 were admitted to Care Coordination and 170 were discharged.

The 60 state-funded Care Coordinators work closely with the 27 existing Community Collaboratives (Systems of Care). All are charged with the responsibility of helping caregivers navigate their way through a complex and at times confusing service delivery system. Acting as "service brokers," Care Coordinators help parents identify their child's needs, choose among available service providers, develop and monitor treatment plans and connect the family to more permanent natural support systems. The goal of care

coordination is to keep children at home and in their communities through collaborative involvement of a variety of service systems (mental health, school, juvenile justice, DCF). The majority of children seen by the Community Collaboratives are not DCF involved.

Additional data is now available on the children discharged from Care Coordination during this quarter. Of the 170 children discharged, an overwhelming majority were boys (129) while the remaining 41 cases were girls. 87 boys were between the ages of 4 and 12 and 42 were 13 years old and older. There was an equal age split for the girls. 81% of the families referred for care coordination (138 children) had no DCF involvement at the time of referral and 76% remained uninvolved with DCF during the course of their involvement. Referrals to care coordination came from a variety of sources including family, DCF, schools, and hospitals, with no one referral source being more prominent than the others. The most frequent presenting problems for the children and youth referred for crisis intervention were depression and suicidal ideation. The next most frequent precipitant for calls to the mobile crisis units were on behalf of children who were exhibiting a cluster of disruptive, aggressive behaviors.

Crisis Stabilization Units:

Crisis Stabilization Units were developed to assist youngster in crisis who need extensive evaluation and support but who do not meet criteria for psychiatric hospitalization. The two programs, one located on the UCONN Health Care Center campus (operated in collaboration with Wheeler Clinic) and one on the campus of the Children's Center in Hamden, opened in June 2003 and to date, have collectively served **over 200 children** within their 8 bed programs. While the program is designed to be short term in nature (15 days) , children often remain longer due to lack of alternative living arrangements and/or lack of immediate outpatient services. During this quarter, the two Crisis Stabilization programs report that approximately two thirds of the children remained beyond the 15-day limit. The average length of stay was between 20 and 30 days.

During this reporting period, **48** children were served within both programs: 24 boys and 24 girls. The children served ranged in age from 7 to 16 with the majority clustering between ages 12 and 16. Family members for 36 of the children served, participated in treatment services that included family therapy, phone contact, visits, etc. The majority of referrals to Crisis Stabilization came from the Mobile Crisis Teams, although some children were admitted directly through local DCF offices and community providers. The most common presenting problems demonstrated by the children admitted to service continue to be depression and suicidal ideation. The next most common cause for admission to the program was oppositional and defiant behavior coupled with aggression. Discharge plans from the units was varied, with the majority of children returning home with community based treatment plans in place. Of the 48 children admitted to care, 30 children returned home, 11 went to foster homes, 2 were placed in residential facilities, 1 was hospitalized, 3 were placed in shelters and 1 was placed in a specialized diagnostic unit for further evaluation.

Intensive Home-Based Services:

DCF continues to fund a statewide network of intensive home-based services. Teams of mental health professionals and support staff work closely with targeted children and their families to provide intensive treatment and rehabilitative services in the child's home. Using best practice and evidenced based models, these teams are often employed to assist families when a child is at risk for psychiatric hospitalization or residential care. These services are also supported by dollars dedicated for the treatment of non-DCF involved children through the Community Mental Health Strategy Board.

Through the existing 15 contracts (24 treatment teams) with private providers, approximately 200 families are served at any given time.

Models currently being utilized include Functional Family Therapy (FFT), Multi-Dimensional Family Therapy (MDFT), and Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS).

Administrative Overview and Summary of Progress:

As State Fiscal Year '05 commences, the Department of Social Services and Department of Children and Families are preparing for the next phase of system reform. With support from the Office of Policy and Management, the two Departments issued a Request for Proposal for an Administrative Services Organization on September 26, 2004. The release of this RFP marks the culmination of significant dialogue with legislators, advocates and providers related to the challenges associated with changing the fiscal and management structure for children's behavioral health. Both Departments remain committed to collaboration and believe that through the procurement of an ASO, services for children and families will be greatly enhanced.

What is an Administrative Services Organization?

An Administrative Services Organization is a state contracted entity that will help DCF and DSS develop a common administrative infrastructure to enhance behavioral health care by improving access to care, coordination of care, and quality of care. Through the services of one contracted organization that reports directly to DSS and DCF, publicly funded behavioral health benefits from the Medicaid program and from DCF grants and contracts will be organized and monitored in a coordinated and integrated fashion.

What will the ASO do?

The ASO will authorize admissions to various levels of care, track the care of individual children and groups of children across services, identify and assist children and families for whom existing services do not appear to be working, help consumers and others identify all available resources, and connect children and families to crisis services. In addition, through the development of a data warehouse, the ASO will be able to provide

each department with an extensive array of reports regarding the quality of services being provided, service gaps and systems problems. Unlike the existing managed care companies, the ASO will not be at financial risk and the clinical protocols and rates will be determined by both Departments with input from parents, consumers, and providers, making it a more transparent and collaborative model.

When will the ASO be operational?

The Request for Proposal for the Administrative Services Organization was released on September 26, 2004 and proposals were due on October 29, 2004. A team of reviewers that includes staff members from DSS and DCF, a children's mental health advocate and two parents of children with mental health needs are currently reviewing the proposals. The Departments plan to complete the evaluation in December. The ASO contract is scheduled to be executed by February 2005. It is anticipated that the ASO will begin operation between April and June of 2005.